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BY THE COMPTROLLER GENERAL

# Report To The Congress

OF THE UNITED STATES

## Federal Funding For State Medicaid Fraud Control Units Still Needed

COMPLETED

ORIGINAL

State Medicaid fraud units, established after Federal support for such units was increased to 90 percent of their costs for fiscal years 1978-80, have increased States' ability to investigate and prosecute Medicaid fraud. However, the units have not become self-supporting as anticipated.

The 27 fraud control units operating as of December 31, 1979, had identified potentially recoverable amounts equal to only about one-half their operating costs. GAO believes the goal of the units becoming self-supporting after September 30, 1980, will be extremely difficult to achieve. According to unit officials, if some Federal funding is not continued, many units likely will cease to exist or will operate less effectively.

The Congress should fund the units beyond September 1980. However, to receive such funding, units should have to demonstrate effective performance based on reasonable standards established by the Department of Health and Human Services.

SUMMARY

UNITED STATES GENERAL ACCOUNTING OFFICE

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HRD-81-2

OCTOBER 6, 1980

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

# FEDERAL FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS STILL NEEDED

## D I G E S T

Medicaid fraud costs American taxpayers millions of dollars annually. To help reduce these losses, the Congress in 1977 enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments authorizing 90-percent Federal matching payments, instead of the normal 50, for fiscal years 1978-80 as an incentive to States to establish Medicaid fraud control units.

It was expected that this financial relief would enable many State governments to establish new units or expand existing ones and that, after the units had been in operation a few years, they would begin to recover from prosecutions amounts equal to or exceeding their operating costs. Most units have not been able to identify and collect more fraudulent overpayments than their operating costs. Those that have may have difficulty continuing to do so unless some Federal funding is continued.

### FRAUD UNITS CAN BE EFFECTIVE; FEDERAL FUNDING SHOULD CONTINUE

The Department of Health and Human Services' (HHS') Office of the Inspector General is responsible for certifying, funding, and monitoring the fraud control units.[1/] As of April 30, 1980, 30 States and the District of Columbia had certified fraud units. GAO reviewed seven.

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1/Effective May 4, 1980, the Department of Education formally commenced operations. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

At the time of GAO's fieldwork, 27 units had been certified. From their effective certification dates through December 31, 1979, these units reported potential recoveries of about $19 million--about one-half their total operating costs of $36 million. However, the accuracy of the recoverable amount is questionable because three of seven units GAO reviewed reported incorrect amounts. Additionally, five of the seven units did not maintain information on the amount of the overpayments identified for recovery that had actually been collected. GAO believes it will be extremely difficult for State fraud units to become self-supporting after September 30, 1980. (See p. 8.)

Although most fraud units may not become self-supporting, they have increased States' ability to investigate and prosecute Medicaid fraud. The additional Federal funding has resulted in increases in the number of staff, cases handled, and convictions. (See p. 11.) Fraud units also deter Medicaid providers from attempting fraud and have had an impact on changing State legislation and Medicaid regulations to make it easier to identify fraud and provide for more stringent penalties. (See p. 14.)

GAO believes that fraud units can be an effective force in combating Medicaid fraud and that their effectiveness should increase as they gain experience in investigating and prosecuting Medicaid fraud.

On April 23, 1980, the House Committee on Interstate and Foreign Commerce reported H.R. 4000, the Medicare and Medicaid Amendments of 1980. The bill authorizes Federal matching payments to States for establishing and operating Medicaid fraud control units at the rate of 90 percent for the first 3 years and 75 percent thereafter. This provision was included as section 336 of H.R. 7765, the Omnibus Reconciliation Act of 1980, which passed the House on September 4, 1980. (See p. 18.)

Many officials connected with fraud units believe that, if some type of continued Federal funding is not provided, many units will cease to exist or operate at a reduced level of effectiveness. Also, the establishment of fraud units in other States is unlikely unless Federal funding is extended beyond September 1980. (See pp. 18 and 38.)

RECOMMENDATION TO THE CONGRESS

The Congress should provide for funding State Medicaid fraud control units beyond September 1980. Such legislation should require HHS to annually certify for continued funding only those units that have demonstrated effective performance based on reasonable performance standards established by HHS. (See p. 20.)

HINDRANCES TO MORE EFFECTIVE OPERATION OF FRAUD UNITS

A number of situations hinder effective operation of the State fraud units:

--Potential fraud cases referred to the units have generally not contained sufficient information to make a meaningful evaluation of fraud prosecution potential. (See p. 23.)

--Investigations have been hampered by problems in their dealings with State Medicaid agencies. Mutual distrust, concern over loss of control of fraud investigations, and personality conflicts contribute to this situation. (See p. 30.)

--Fraud units have experienced problems in hiring and retaining qualified staff due to (1) low State salaries for auditors, investigators, and attorneys, (2) State budget constraints affecting available funds and personnel ceilings, and (3) the uncertainty of Federal funding after September 1980. (See p. 35.)

--Fraud unit staff have not received adequate training. The Office of the Inspector General can further assist the units in training staff. (See p. 40.)

Two fraud units GAO reviewed did not implement the formal procedures HHS had approved to assure prosecution of suspected Medicaid fraud cases on a statewide basis. Another unit did not initially provide for effective coordination between the unit and the attorney general's office for prosecution of Medicaid fraud. (See p. 47.)

RECOMMENDATIONS TO HHS

The Secretary should direct the HHS Inspector General to:

--Verify, on a sample basis, the accuracy of the statistics contained in the State fraud units' quarterly reports on their fraud investigation activities. (See p. 20.)

--Determine which fraud units do not have adequate procedures for following up on the amount of overpayments actually collected and require them to establish appropriate procedures. (See p. 20.)

--Develop criteria, in consultation with fraud units and State Medicaid agencies, to guide Medicaid agencies on the extent to which a potential fraud case should be developed before referral to a fraud unit and the types of data and analysis that should be included. (See p. 32.)

--Develop a fraud unit training manual incorporating the most effective techniques and methods identified by the units for dealing with Medicaid provider fraud. (See p. 43.)

--Reassess the adequacy of arrangements now in effect in States where the attorney general's office does not have statewide prosecution authority, or if it does, the unit is located outside that office to

assure that prosecution can be carried out as needed statewide. (See p. 52.)

--Decertify State fraud units that fail to meet the statewide prosecution requirement of the law and regulations. (See p. 52.)

--Issue guidelines on essential elements that should be included in a fraud unit's formal procedures with local prosecutors or working relationships with the State attorney general to assure statewide prosecution. (See p. 52.)

HHS AND STATE COMMENTS

HHS and four of the seven State fraud units GAO reviewed commented on a draft of this report. The fraud units commented essentially on statements in the report relating to their particular unit, and their comments are incorporated where appropriate.

HHS generally concurred with GAO's recommendations. It said that:

--The accuracy of the statistics contained in fraud units' quarterly reports and the adequacy of the units' procedures for following up on the amount of overpayments actually collected will be reviewed during onsite recertification visits. (See p. 20.)

--A model memorandum of understanding between State Medicaid agencies and fraud units has been developed which will include criteria for referral of potential fraud cases. GAO also noted that proposed revisions to the Federal regulations would require that the memorandum include criteria and formats for the referral of cases. (See p. 32.)

--A fraud unit training manual will be developed as additional staff are added to the division administering the program. (See p. 43.)

--The proposed revisions to the Federal regulations contain requirements relating to the type of formal procedures that fraud units must establish with local prosecutors to assure statewide prosecution of fraud cases. (See p. 52.)

GAO believes that, if the revised regulations are adopted and the other above actions are taken, they will satisfy the intent of its recommendations.

HHS disagreed with the position GAO took in a draft of this report pertaining to the type of formal procedures that fraud units are required to establish to assure statewide prosecution of fraud cases. GAO has clarified its position in this report. (See p. 52.)

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ABBREVIATIONS

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|---|---|
| GAO | General Accounting Office |
| HCFA | Health Care Financing Administration |
| HHS | Department of Health and Human Services |
| MMIS | Medicaid Management Information System |
| OIG | Office of the Inspector General |